BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.86.702, 37.86.805, 37.86.1001, 37.86.1004, 37.86.1005, 37.86.1006, 37.86.1105, 37.86.1506, 37.86.1807, 37.86.2105, 37.86.2205, 37.86.2207, 37.86.2402, 37.86.2405, 37.86.2505, and 37.86.2605 pertaining to audiology services, dental, outpatient drug services, home infusion therapy, durable medical equipment and medical supplies, optometric services, EPSDT, transportation, and ambulance services	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On October 10, 2007, at 10:00 a.m., the Department of Public Health and Human Services will hold a public hearing in the Sapphire Room, 2401 Colonial Drive, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process (including reasonable accommodations at the hearing site) or who need an alternative accessible format of this notice. If you need an accommodation, contact the department no later than 5:00 p.m. on October 1, 2007. Please contact Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210; telephone (406)444-4094; fax (406)444-1970; e-mail dphhslegal@mt.gov.

3. The rules as proposed to be amended provide as follows. New matter is underlined. Matter to be deleted is interlined.

<u>37.86.702 AUDIOLOGY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS</u> (1) through (5) remain the same.

(6) Basic audio assessments must include for each ear under earphones:

(a) and (b) remain the same.

(c) Speech discrimination (word recognition) test under PB max conditions, and either pure tone bone conduction thresholds at the frequencies specified in (6)(a), or tympanometry, including tympanogram, acoustic reflexes, and static compliance. ~~A hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine adequacy of fit of the hearing aid for the recipient's needs. A hearing aid fitting must include at~~

~~least one follow-up visit and warranty coverage for the hearing aid for a period of at least two years.~~

(8) remains the same but is renumbered (7).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.805 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lower of the following for covered hearing aid services and items:

(a) remains the same.

(b) the amount specified for the particular service or item in the department's fee schedule. The department adopts and incorporates by reference the department's fee schedule dated ~~January 2005~~ October 2007 ~~which sets forth the reimbursement rates for hearing aid services~~. A copy of the department's fee schedule is posted at http://medicaidprovider.hhs.mt.gov. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.1001 DENTAL SERVICES, DEFINITIONS For purposes of this subchapter, the following definitions apply:

(1) "By-report method" means the department reimburses a percent of the provider's usual and customary charges for a procedure code for which no fee has been assigned.

(1) through (6) remain the same but are renumbered (2) through (7).

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.1004 REIMBURSEMENT METHODOLOGY FOR SOURCE BASED RELATIVE VALUE FOR DENTISTS (1) For procedures listed in the relative values for dentists scale, reimbursement rates shall be determined using the following methodology:

(a) The fee for a covered service shall be the amount determined by multiplying the relative value unit specified in the relative values for dentists scale by the conversion factor specified in (1)(b) ~~or (c)~~. The department adopts and incorporates by reference the relative values for dentists scale published in ~~2004 for use in 2005 and 2006~~ 2007. Copies of the relative values for dentists scale are available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) The conversion factor used to determine the Medicaid payment amount

for services provided to eligible individuals ~~age 18 and above is $21.77~~ is $30.85.

~~(c) The conversion factor used to determine the Medicaid payment amount for services provided to eligible individuals age 17 and under is $28.30.~~

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.1005 DENTAL SERVICES, REIMBURSEMENT (1) through (1)(b) remain the same.

(2) For dental services that are not listed in the RVD scale, the department shall pay the lowest of the following for dental services covered by the Medicaid program:

(a) remains the same.

(b) the amount determined using the by-report method as 85% of the provider's approved usual and customary charge for the service. ~~follows:~~

~~(i) for covered dental services provided to persons age 18 and over, 65.2% of the provider's usual and customary charge for the service;~~

~~(ii) for covered dental services provided to persons age 17 and under, 80% of the provider's usual and customary charge for the service.~~

~~(3) Reimbursement for services delivered to adults is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 65.2% of the provider's usual and customary charge for the service. Services delivered to adults are services provided while the recipient is age 21 and over.~~

~~(4) Reimbursement for services delivered to a child is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 80% of the provider's usual and customary charge for the service. Services delivered to children are services provided while the recipient is up to and including age 17.~~

~~(5) Reimbursement for services delivered to individuals age 18 through 20 is the fee specified in the fee schedule for adults, or if reimbursement is based on the "by report" method 80% of the provider's usual and customary charge for the service.~~

(6) through (9) remain the same but are renumbered (3) through (6).

~~(10)~~ (7) Payment for orthodontia will be as follows:

(a) Full band orthodontia for Medicaid recipients who have cleft lip/palate, craniofacial anomalies or malocclusions caused by traumatic injury and interceptive orthodontia for Medicaid recipients who have posterior crossbite with shift, anterior crossbite and/or anterior deep bite at 80% or greater vertical incisor overbite, will be reimbursed at 85% of the provider's usual and customary charge, subject to the maximum allowable charge as published in the department's ~~Orthodontic Coverage and Reimbursement Guidelines, December 1999~~ Dental and Denturist Program Provider Manual effective October 2007.

(b) and (c) remain the same.

(d) Maximum allowable charges for each phase of orthodontic treatment, time lines for orthodontic phases of care, and the services included in each phase of orthodontic care are listed in the department's ~~Orthodontic Coverage and Reimbursement Guidelines~~ Dental and Denturist Program Provider Manual. The department ~~hereby~~ adopts and incorporates ~~herein~~ by reference the department's

~~Orthodontic Coverage and Reimbursement Guidelines updated through December 1999~~ Dental and Denturist Program Provider Manual effective October 2007. The guidelines, issued by the department to all providers of orthodontic services, inform providers of the requirements applicable to the delivery of services. A copy of the department's ~~Orthodontic Coverage and Reimbursement Guidelines~~ Dental and Denturist Program Provider Manual is available from the Department of Public Health and Human Services, Health Resources Division, ~~Acute Services Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.1006 DENTAL SERVICES, COVERED PROCEDURES (1) For purposes of specifying coverage of dental services through the Medicaid program, the department adopts and incorporates by reference the Dental and Denturist ~~Services~~ Program Provider Manual effective ~~July 2006~~ October 2007. The Dental and Denturist ~~Services~~ Program Provider Manual~~, provided to providers of those services,~~ informs the providers of the requirements applicable to the delivery of services. Copies of the manual are available on the Montana Medicaid provider web site at ~~www.dphhs.mt.gov~~ http://medicaidprovider.hhs.mt.gov and from the Department of Public Health and Human Services, Health Resources Division, ~~Acute Services Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Dentists who are Medicaid provider participants under ARM 37.85.401 may bill medical CPT procedure codes as provided in ARM 37.85.212 and 37.86.101 for any Medicaid covered medical procedure that they are allowed to provide under the Dental Practice Act that is not otherwise listed in the Dental and Denturist ~~Services~~ Program Provider Manual.

(3) through (10) remain the same.

(11) Full band orthodontia for recipients 21 and younger who have malocclusion caused by traumatic injury or needed as part of treatment for a medical condition with orthodontic implications are covered in the department's ~~Orthodontic Coverage and Reimbursement Guidelines, published December 1999~~ Dental and Denturist Program Provider Manual. ~~The department adopts and incorporates by reference the department's Orthodontic Coverage and Reimbursement Guidelines updated through December 1999. The guidelines, issued by the department to all providers of orthodontic services, informs providers of the requirements applicable to the delivery of services. A copy of the department's Orthodontic Coverage and Reimbursement Guidelines is available from the Department of Public Health and Human Services, Health Resources Division, Acute Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

(12) through (17) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.86.1105 OUTPATIENT DRUGS, REIMBURSEMENT (1) remains the same.

(2) The dispensing fee for filling prescriptions shall be determined for each pharmacy provider annually.

(a) remains the same.

(b) The dispensing fees assigned shall range between a minimum of $2.00 and a maximum of ~~$4.70~~ $4.86.

(c) and (d) remain the same.

(3) In-state pharmacy providers that are new to the Montana Medicaid program will be assigned an interim $3.50 dispensing fee until a dispensing fee questionnaire, as provided in (2), can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated in accordance with (2) for the pharmacy or the ~~$4.70~~ $4.86 dispensing fee. Failure to comply with the six months dispensing fee questionnaire requirement will result in assignment of a dispensing fee of $2.00.

(4) through (7) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.1506 HOME INFUSION THERAPY SERVICES, REIMBURSEMENT

(1) Subject to the requirements of these rules, the Montana Medicaid program will pay for home infusion therapy services on a fee basis, as specified in the department's home infusion therapy services fee schedule. The department adopts and incorporates by reference the Home Infusion Therapy Services Fee Schedule dated ~~April 2004~~ October 2007. A copy of the department's fee schedule is posted at the Montana Medicaid provider web site at http://medicaidprovider.hhs.mt.gov. A copy of the Home Infusion Therapy Services Fee Schedule may also be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The specified fees are on a per day or a per dose basis as specified in the fee schedule. The fees are bundled fees which cover all home infusion therapy services as defined in ARM 37.86.1501.

(2) through (4)(c) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.86.1807 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, FEE SCHEDULE (1) remains the same.

(2) Prosthetic devices, durable medical equipment, and medical supplies shall be reimbursed in accordance with the department's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, effective ~~July 2006~~ October 2007, which is adopted and incorporated by reference. A copy of the department's fee schedule is posted at the Montana Medicaid provider web site at http://medicaidprovider.hhs.mt.gov. A copy of the department's Prosthetic Devices, Durable Medical Equipment, and Medical Supplies Fee Schedule may also be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) through (4) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2105 EYEGLASSES, REIMBURSEMENT (1) through (2)(a)(ii) remain the same.

(3) The department adopts and incorporates by reference the department's Eyeglasses Fee Schedule effective ~~July 2006~~ July 2007 ~~which sets forth the reimbursement rates for eyeglasses, dispensing services and other related supplies for optometric services~~. A copy of the department's fee schedule is posted at the the Montana Medicaid provider web site at http://medicaidprovider.hhs.mt.gov. A copy of the department's fee schedule may also be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.2205 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REQUIRED SCREENING AND PREVENTIVE SERVICES (1) through (3) remain the same.

(4) The department ~~hereby~~ adopts and incorporates ~~herein~~ by reference the department's provider manual dated November 2006 posted at http://medicaidprovider.hhs.mt.gov ~~updated through June 2000~~. The provider manual, issued by the department to all providers of EPSDT services, informs providers of the requirements applicable to the delivery of services. A copy of the department's EPSDT provider manual is available from the Department of Public Health and Human Services, Health Resources Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT~~,~~ 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2207 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT (1) Reimbursement for an EPSDT service, except as otherwise provided in this rule, is the lowest of the following:

(a) through (c) remain the same.

(d) for public agencies, cost based reimbursement as determined in accordance with OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments as established and approved by the department. The department adopts and incorporates by reference the OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments, as further amended August 29, 1997. A copy of OMB Circular A-87 may be obtained from the Department of Public Health and Human Services, Health Resources Division, ~~Managed Care Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Reimbursement for outpatient chemical dependency treatment, nutrition, and private duty nursing services is specified in the department's ~~EPSDT~~ fee schedule. This cross reference does not outline reimbursement. The department adopts and incorporates by reference the department's private duty nursing services EPSDT Fee Schedule dated ~~July 2003~~ January 2007 and the nutrition EPSDT Fee Schedule dated July 2006. The fee schedules are posted at http://medicaidprovider.hhs.mt.gov. Reimbursement for outpatient chemical dependency treatment is outlined in ARM 37.27.912. A copy of the fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, ~~Children's Mental Health Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) Reimbursement for the therapeutic portion of therapeutic youth group home treatment services is the lesser of:

(a) the amount specified in the department's Medicaid Mental Health Fee Schedule. The department adopts and incorporates by reference the department's Medicaid Mental Health and Mental Health Services Plan, Individuals Under 18 Years of Age Fee Schedule dated July 15, 2005. A copy of the fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, ~~Children's Mental Health Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or

(b) through (8) remain the same.

(9) Reimbursements for school based health related services are specified in the School Based Health Service Fee Schedule dated ~~September 1, 2005~~ October 2007 posted at http://medicaidprovider.hhs.mt.gov. Rates are 90% of the fees as specified in (1)(a) through (d), adjusted to reimburse these services at the federal matching assistance percentage (FMAP) rate.

(10) The department will not reimburse providers for two services that duplicate one another on the same day. The department adopts and incorporates by reference the Medicaid Children's Mental Health Plan and Children's Mental Health Services Plan (CHMSP) Services Excluded from Simultaneous Reimbursement dated September 1, 2005. A copy of the CHMSP Services Excluded from Simultaneous Reimbursement is posted on the internet at the department's ~~home page~~ web site at www.dphhs.mt.gov/mentalhealth/children/childrensmentalhealthservicesmatrix.pdf or may be obtained by writing the Department of Public Health and Human Services, Health Resources Division, ~~Children's Mental Health Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(11) Information regarding current reimbursement or copies of fee schedules for EPSDT services may be obtained from the Department of Public Health and Human Services, Health Resources Division, ~~Managed Care Bureau,~~ 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2402 TRANSPORTATION AND PER DIEM, REQUIREMENTS

(1) and (2) remain the same.

(3) Coverage for transportation and per diem is only available for

transportation and per diem to the site of medical services at the provider closest to the locality of the recipient or to a preferred out-of-state hospital, as defined in ARM 37.86.2901, if prior authorization requirements have been met.

(a) through (15)(h) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.2405 TRANSPORTATION AND PER DIEM, REIMBURSEMENT

(1) through (1)(b) remain the same.

(2) The department adopts and incorporates by reference the department's Personal Transportation Fee Schedule effective ~~July 2006~~ November 2006 which sets forth the reimbursement rates for transportation, per diem, and other Medicaid services. A copy of the department's fee schedule is posted at the Montana Medicaid provider web site at http:/medicaidprovider.hhs.mt.gov. A copy of the fee schedule may also be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) and (4) remain the same.

(5) Mileage for transportation in a personally owned vehicle is reimbursed at the rate of ~~$.13~~ $0.22 per mile.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.2505 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT (1) through (1)(b) remain the same.

(2) The department ~~hereby~~ adopts and incorporates by reference the department's fee schedule dated ~~July 2003~~ November 2006 which sets forth the reimbursement rates for specialized nonemergency medical transportation services and other Medicaid services. A copy of the fee schedule is posted at the Montana Medicaid provider web site at http://medicaidprovider.hhs.mt.gov. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.2605 AMBULANCE SERVICES, REIMBURSEMENT (1) through (1)(b) remain the same.

(2) The department adopts and incorporates by reference the department's Ambulance Fee Schedule effective ~~July 2006~~ October 2007 ~~which sets forth the reimbursement rates for ambulance services and other Medicaid services~~. A copy of the fee schedule is posted at the Montana Medicaid provider web site at http://medicaidprovider.hhs.mt.gov. A copy of the department's fee schedule may also be obtained from the Department of Public Health and Human Services, Health

Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) through (4) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

4. The Montana Medicaid program provides medical assistance to low income and disabled residents of Montana. The state of Montana and the federal government jointly fund the program. These rule amendments are necessary to: 1) increase Medicaid provider fees for hearing aid services, home infusion therapy durable medical equipment, ambulance services, dental services, and private duty nursing as authorized by the 2007 Legislature; 2) edit to improve clarity of writing and to update the reference to current fee schedule dates; 3) update the reference to provider manual dates to the most current version; 4) increase the maximum dispensing fee for pharmacy providers; 5) allow transportation to some preferred hospitals with prior approval, rather than the closest facility; and 6) update the mileage rate for some transportation providers. These rule changes impact approximately 84,000 Medicaid clients and 6,000 providers.

ARM 37.86.702

ARM 37.86.702 is amended to remove redundant language. The deleted language also appears in ARM 37.86.702(7). This change has no substantive effect.

ARM 37.86.805(1), 37.86.1506(1), 37.86.1807(2), 37.86.2207(2), and 37.86.2605(2)

These rules are amended to update the references to the fee schedule for hearing aid services, home infusion therapy, durable medical equipment, and ambulance service providers (for nontransportation costs only). The updated fee schedules effective October 1, 2007, establish the current provider fees authorized in House Bill 2 (HB 2) of the 2007 special session. The proposed fee schedules are available on the department's web site. The proposed rate increases will have a general fund impact of $116,000 in state funds and $253,000 in federal funds for SFY 2008 and a general fund impact of $226,000 in state funds and $492,000 in federal funds for SFY 2009.

ARM 37.86.1001, 37.86.1004, and 37.86.1005

ARM 37.86.1001 is amended to add a definition of the "by-report" method of reimbursement. ARM 37.86.1004 is amended to update the reference of the relative values for dentists' scale from 2004 to 2007. The rule is also amended to increase the conversion factor for dental services to $30.85 and adopt one conversion factor for Medicaid recipients regardless of age. ARM 37.86.1005(3) is amended to set the provider rate for dental fees that are not listed in the relative value for dentists scale (RVD) to a uniform by-report methodology of 85% of the providers' approved usual and customary charges. Prior to this change the rate was set at 62.5%, for adults, and 80%, for children, of the providers' usual and customary charges. This

amendment in conjunction with the amendment to ARM 37.86.1004 will have a fiscal impact of $462,000 state general fund and $1,000,000 in federal funds for SFY 2008 and $508,000 state general fund $1,105,000 in federal funds for SFY 2009.

ARM 37.86.1006

ARM 37.86.1006 amends the reference to the department's Dental and Denturist Program Provider Manual, which is posted on the department's web site. This change is expected to have no fiscal impact to the department and no material effects on Medicaid recipients or Medicaid providers.

ARM 37.86.1105

ARM 37.86.1105(2)(b) and (3) are amended to increase the maximum dispensing fee for Montana Medicaid pharmacy providers from $4.70 to $4.86. The proposed rate increase will have an estimated general fund impact of $32,000 in state funds and $69,000 in federal funds for SFY 2008 and $61,000 in state fund and $133,000 in federal funds for SFY 2009.

ARM 37.86.2105

ARM 37.86.2105 is amended to update references to the current fee schedules for eyeglass providers posted on the department's web site in a manner which allows for specificity in the reference. There is no fiscal impact.

ARM 37.86.2205

ARM 37.86.2205(4) is amended to update references to the current provider manual for EPSDT services on the department's website. This change has no fiscal impact.

ARM 37.86.2207

ARM 37.86.2207 states the EPSDT fee schedule for reimbursement of outpatient chemical dependency treatment, nutrition, and private duty nursing services. ARM 37.86.2207(2) is amended to increase the Private Duty Nursing fee schedule because the previous rates were not competitive enough to provide sufficient coverage. The department is committed to ensuring there is a well-staffed pool of nurses to deliver care to Medicaid recipients. The private duty nursing rate was implemented incrementally, first on January 1, 2007 and again on July 1, 2007. Estimated general fund cost for the increase to the private duty nursing rate is $678,000 in state funds and $1,477,00 in federal funds for SFY 2008, and $790,000 in state funds and $1,721,000 in federal funds for SFY 2009.

ARM 37.86.2207 is also being amended to remove the reference to a fee schedule for outpatient chemical dependency treatment. Provider information regarding instructions for determination of eligibility for services and billing outpatient chemical dependency treatment is now found at ARM 37.27.912.

ARM 37.86.2207(9) regarding school-based service providers is being amended to update the fee schedule date. There is no fiscal impact to the Montana Medicaid program because school-based services are funded through state appropriations to education and are reimbursed at the FMAP rate, which changes each October.

ARM 37.86.2402

ARM 37.86.2402 provides for the payment of transportation costs for certain Medicaid recipient required travel. The amendment to ARM 37.86.2402(3) allows the payment of certain travel costs to preferred hospitals upon prior authorization, rather than only to "the site of medical services at the provider closest to the locality of the recipient". The rule change allows the payment of transportation costs for clients to a preferred hospital rather than the closest facility when the department finds the preferred hospital is the better choice. Payment decisions will be made using the prior authorization process already in place in collaboration with the Health Resources Division's Hospital and Clinical Services Bureau.

The department reimburses approximately 125 out-of-state facilities per year for both outpatient and inpatient services. Generally, only 45 of these facilities provide inpatient services with ten providing the vast majority of the services on a regular basis. The services provided by these facilities are usually cancer, burn, trauma, transplant, or surgical services that cannot be provided at a Montana facility. Since March 2002, the department has required prior authorization for out-of-state inpatient services.

ARM 37.86.2405 and 37.86.2505

ARM 37.86.2405 states the mileage rate for some transportation reimbursement. The mileage reimbursement for transportation in a personally owned vehicle is changed from $0.13 to $0.22. The transportation increase was effective on November 1, 2006. The previous rate was set in 2002. Estimated general fund impact for the change to the transportation rules ARM 37.86.2402(3) and 37.86.2405(2) and (5), and also ARM 37.86.2505(2) is expected to be $303,291 for SFY 2008 and $303,291 for SFY 2009 in general funds.

5. The bill sponsor notice requirements of 2-4-302, MCA, do not apply. This proposal notice does not initially implement new or amended legislation.

6. Interested persons may submit comments orally or in writing at the hearing. Written comments may also be submitted to Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210, no later than 5:00 p.m. on October 18, 2007. Comments may also be faxed to (406)444-1970 or e-mailed to dphhslegal@mt.gov. The department maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of

interest. To be included on such a list, please notify this same person or complete a request form at the hearing.

7. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice as printed in the Montana Administrative Register, but advises all concerned persons that, in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. The web site may be unavailable at times, due to system maintenance or technical problems.

8. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ Geralyn Driscoll
Rule Reviewer

/s/ John Chappuis for
Director, Public Health and Human Services

Certified to the Secretary of State September 10, 2007.